fraserhealth

ADVANCE CARE PLANNING (ACP) RECORD

ACP, SERIOUS ILLNESS & GOALS OF CARE CONVERSATIONS
This is a reference and may not reflect most up to date conversations.

Tools to facilitate ACP conversations:
- FH Core Elements
- Serious Illness Conversation Guide (SICG)
- Goals of Care

Select most appropriate tool based on purpose of conversation, acuity/prognosis of illness, and/or treatment decision making.
See back for further details.

Previous Advance Care Planning documentation: Reviewed and copy in Greensleeve (if applicable):

☐ Advance Care Planning Record ☐ Advance Care Plan
☐ Representation Agreement ☐ Advance Directive
☐ Provincial No CPR ☐ Identification of SDM
☐ Medical Orders for Scope of Treatment (MOST)

Type of conversation and tool utilized. (check one)	**Brief summary of key outcomes/decisions of conversation.**	**Recommendations/Next Steps**
☐ FH Core Elements ☐ Serious Illness Conversation Guide (SICG) ☐ Goals of Care (GoC)		Next steps *patient/client/resident/SDM* responsible for (eg. learn about illness, talk to family, legal/financial planning): Next steps *recorder/HCP* responsible for: 1) Recommend review of discussion with: 2)
	Detailed Notes can be found: Dated:	

Date (dd/mm/yyyy)	Name & discipline of recorder; participants & relationship:	Site/Location:	Signature

ACP Records completed in non-acute settings please fax to 604-587-3748

ADVANCE CARE PLANNING (ACP) RECORD

The purpose of the ACP Record is to document the outcomes of **Advance Care Planning, Serious Illness, and Goals of Care conversations.** This form is to be used by all members of the health care team (e.g., physicians, nurse practitioners, nurses, social workers, respiratory therapists) in all program areas (acute and community) as a written communication tool.

How do / know which ACP pathway, tool, or technique to utilize? ***Determine what the goal/outcome of the conversation*** *is ...*

My patient/client is not acutely ill and is being seen in an outpatient clinic/primary care/specialty care setting ... they may already have had* ACP *conversations and documents...

Diagnosed with chronic or serious illnesses

Core Elements:

ACP conversations are ongoing and may include any combination of the five (5) Core Elements.

1. S.P.E.A.K to adult about Advance Care Planning

Determine if the adult has:

- Chosen a **Substitute Decision Maker** (Representative appointed or TSDM)
- Thought about **Preferences** for decision making.
- Any previously **Expressed wishes** (spoken, written, or recorded).
- Written an **Advance Directive**

Then assess the adult and/or SDM's:

- Level of **Knowledge** regarding diagnosis, treatment options, risks and benefits.

2. Learn about & understand the adult & what is important to them.

3. Clarify understanding & provide medical information about disease progression, prognosis & treatment options.

4. Ensure interdisciplinary involvement and utilize available resources

5. Define goals of care, document & create plan.

My patient/client may or may not be acutely ill ... has a chronic life limiting illness ... has frequent exacerbation and/or hospitalization ... has ongoing decline ... is being transferred locations ...

Identified as having 1-2 years prognosis

Serious Illness Conversation Guide (SICG)

Serious Illness conversations are part of the Advance Care Planning process and take place when an adult has a serious life limiting illness and prognosis of 1-2 years.

The goal of these conversations is to better understand persons' goals, values and priorities that will inform their future care, not to obtain a medical order.

The SICG is an intervention and tool that supports and facilitates conversations between clinicians, seriously ill adults and their families.

1. Set up conversation
2. Assess understanding and preferences
3. Share prognosis
4. Explore key topics (goals, fears/worries, sources of strength, critical abilities, trade-offs, family)
5. Close the conversation
6. Document your conversation
7. Communicate with key clinicians

Conversations follow a prewritten script in order to utilize specific, evidence based language.

My patient/client would benefit from having a MOST order ... a medically indicated treatment is being offered and consent is required ...

Ongoing decline or transfer of location

Goals of Care

Goals of care conversations are part of the Advance Care Planning process and consist of putting prior Advance Care Planning and Serious Illness conversations into the current clinical context, resulting in medical orders.

See Just Ask: A Conversation Guide for Goals of Care Discussions. The majority of MOST orders and Goals of Care Conversations take place with people who have advanced medical illnesses and may or may not be in the last years of their life.

These are brief summaries. If you require additional guidance/clarification then please refer to the FH ACP/MOST policy for detailed information.